Exhibit A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

JEAN LIN,

Plaintiff,

07-CV-3218 (Judge Holwell)

-against-

AMENDED ANSWER, AFFIRMATIVE DEFENSES and COUNTERCLAIM

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

Defendant, Metropolitan Life Insurance Company ("MetLife"), by and through its undersigned attorneys, hereby answers the Complaint of Plaintiff, and, as to each and every allegation therein:

1. Admits, upon information and belief, that Plaintiff Jean Lin was the wife of the deceased, Bang Lin, and that they were citizens of the State of California, and denies remaining allegations.

2. Denies the allegations set forth in paragraph 2 of the Complaint, and further states that MetLife is a corporation organized and existing under the laws of State of New York, with its principal place of business in the State of New York.

3. Admits that this Court has personal jurisdiction over MetLife in this action, admits that MetLife engages in business in the State of New York, and denies remaining allegations.

4. Admits that the matter in controversy alleges damages in the sum or value of at least $75,000.00, exclusive of interest and costs, and denies remaining allegations.

5. Admits that this Court has subject matter jurisdiction over this action.

6. Admits that venue in this district is proper, admits that MetLife's principal place of business is in the State of New York, and denies remaining allegations.

AS AND FOR PLAINTIFF'S CLAIM FOR RELIEF

7. Admits that on or about August 5, 2004, Mr. Bang Lin completed an application seeking $1,000,000 in MetLife life insurance, and denies remaining allegations.

8. Admits that on or about August 31, 2004, MetLife issued a Term Life Insurance Policy with a face value of $1,000,000, Policy Number 204 126 416 ET (hereinafter "the Policy"), on the life of Mr. Lin (hereinafter "the Decedent"), wherein Plaintiff was named owner and primary beneficiary of the Policy, and denies remaining allegations.

9. Admits, upon information and belief, that the Decedent died on August 11, 2006, and denies remaining allegations.

10. Admits that on or about September 19, 2006, Plaintiff submitted a claim for death benefits under the Policy, and denies remaining allegations.

11. Admits that by letter dated February 5, 2007, MetLife denied Plaintiff's claim for death benefits under the Policy, and respectfully refers the Court to the text of that letter, attached hereto as *Exhibit 1*, as to the contents therein, and denies remaining allegations.

12. Denies the allegations set forth in paragraph 12 of the Complaint, and respectfully refers the Court to the text of MetLife's denial letter, *Exhibit 1*, for the basis for the claim denial.

13. Admits, upon information and belief, the allegations set forth in paragraph 13 of the Complaint.

14. Denies knowledge or information sufficient to form a belief as to the allegations set forth in paragraph 14 of the Complaint.

15. Denies knowledge or information sufficient to form a belief as to the allegations set forth in paragraph 15 of the Complaint.

16. Denies knowledge or information sufficient to form a belief as to the allegations set forth in paragraph 16 of the Complaint.

17. Denies knowledge or information sufficient to form a belief as to the allegations set forth in paragraph 17 of the Complaint.

18. Denies knowledge or information sufficient to form a belief as to the allegations set forth in paragraph 18 of the Complaint.

19. Denies the allegations set forth in paragraph 19 of the Complaint.

20. Denies the allegations set forth in paragraph 20 of the Complaint.

21. Denies the allegations set forth in paragraph 21 of the Complaint.

22. Denies the allegations set forth in paragraph 22 of the Complaint.

23. Denies the allegations set forth in paragraph 23 of the Complaint.

AFFIRMATIVE DEFENSES

AS AND FOR A FIRST AFFIRMATIVE DEFENSE

1. The Complaint, and each purported cause of action contained therein, fails to state a claim upon which relief can be granted.

AS AND FOR A SECOND AFFIRMATIVE DEFENSE

2. Plaintiff's claims are barred in whole or in part by the equitable doctrines of laches, waiver, estoppel and/or unclean hands.

AS AND FOR A THIRD AFFIRMATIVE DEFENSE

3. Plaintiff's claims are barred because MetLife's actions were made in good faith, were reasonable, were based on substantial evidence, and were not arbitrary or capricious.

AS AND FOR A FOURTH AFFIRMATIVE DEFENSE

4. MetLife affirmatively states that the Decedent made negligent and/or intentional misrepresentations during the application process, or otherwise failed to provide information during the application process to the best of his knowledge and belief, in light of the facts then known to him. These misrepresentations during the application process were material to the issue of whether the Decedent would receive insurance coverage from MetLife, and how much insurance coverage would be issued by MetLife. MetLife reasonably relied upon these misrepresentations in issuing insurance coverage to the Decedent. Had the Decedent responded truthfully and accurately within the policy application, MetLife would not have issued the Policy to him, or would have issued coverage under the Policy subject to different terms, limitations, and premiums. Accordingly, the Policy is void *ab initio*.

COUNTERCLAIM

COMES NOW Defendant/Counter-Claimant, METLIFE, and hereby files this Counterclaim against Plaintiff, JEAN LIN, and states as follows:

PARTIES, JURISDICTION, AND VENUE

1. MetLife is an insurance company organized and existing under the laws of the State of New York, with its principal place of business in the State of New York, and is authorized to do business in the State of New York.

2. Upon information and belief, Jean Lin is a citizen of the State of California.

3. Jurisdiction and venue are proper herein because MetLife resides in New York, and this Court has jurisdiction over the action filed by Plaintiff.

GENERAL ALLEGATIONS

1. This is an action for rescission of, or alternatively for declaratory judgment relating to, a MetLife Term Life Insurance Policy, Policy Number 204 126 416 ET ("the Policy"), on the life of Bang Lin ("the Decedent").

2. The Policy had a face amount of $1,000,000.

3. On August 5, 2004, the Decedent applied for life insurance coverage by completing and executing a document entitled, "Application for Individual and Multi-Life Life Insurance" ("the Application"). A copy of the Application is attached hereto as *Exhibit 2*.

4. Question 21(d) of Part I of the Application states, "Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had: (Provide details for each Yes answer below.) Ulcers; colitis; *hepatitis*; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines?" (emphasis added).

5. In response to Question 21(d), the Decedent checked, "No."

6. Question 22(a) of Part I of the Application states, "Has any person proposed for insurance: (Provide details for each Yes answer below.) In the past six months, taken any medication or been under observation or treatment?"

7. In response to Question 22(a), the Decedent checked, "No."

8. Question 22(b) of Part I of the Application states, "Has any person proposed for insurance: (Provide details for each Yes answer below.) Scheduled any: doctor's visits; medical care; or surgery for the next six months?"

9. In response to Question 22(b), the Decedent checked, "No."

10. Question 22(c) of Part I of the Application states, "Has any person proposed for insurance: (Provide details for each Yes answer below.) During the past five years had any: checkup; health condition; or hospitalization not revealed above?"

11. In response to Question 22(c), the Decedent checked, "No."

12. Question 5(d) of Part II of the Application states, "Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had: Ulcers; colitis; *hepatitis*; cirrhosis; or any other disease or disorder of: the liver, gallbladder, stomach, or intestines?" (emphasis added).

13. In response to Question 5(d), the Decedent checked, "No."

14. Question 6 of Part II of the Application states, "Are you now, or within the last six months, under observation or taking medication or treatment (Including over the counter medications, vitamins, herbal supplements, etc.)?"

15. In response to Question 6, the Decedent checked, "No."

16. Question 7 of Part II of the Application states, "Do you have any doctor's visits, medical care, or surgery scheduled?"

17. In response to Question 7, the Decedent checked, "No."

18. Question 8(a) of Part II of the Application states, "Other than the above, during the past five years have you had any [c]heckup; electrocardiogram; chest x-ray or medical test?"

19. In response to Question 8(a), the Decedent checked, "No."

20. Question 8(b) of Part II of the Application states, "Other than the above, during the past five years have you had any [i]llness; injury; or health condition not revealed above; or

have been recommended to have any: treatment, hospitalization; surgery; medical test; or medication?"

21. In response to Question 8(b), the Decedent checked, "No."

22. In executing the Application, the Decedent agreed to having read it and that all statements were true and complete. In addition, the Decedent acknowledged that his statements were the basis of any policy issued and that no insurance would take effect unless: "(a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application." *See Exhibit 2* attached hereto.

23. In reliance upon the representations made by the Decedent during the application process, MetLife issued the Policy on August 31, 2004, in the "Select Preferred Nonsmoker Class" with a face amount of $1,000,000.

24. At the time of the issuance of the Policy, Plaintiff was the named owner and beneficiary.

25. On or about September 19, 2006, Plaintiff submitted a claim for death benefits under the Policy. A copy of the MetLife Individual Life Death Claim Form is attached hereto as *Exhibit 3*.

26. Because the Decedent died within two years of the issuance of the Policy, MetLife conducted an investigation into the circumstances surrounding the Decedent's death.

27. Pursuant to MetLife's investigation, it was determined that the Decedent misrepresented material information in the Application, including his medical history. Specifically, Decedent's medical records revealed that he had a history of hepatitis B, received treatment (including but not limited to being prescribed Interferon) for hepatitis B from

September 5, 1998 to August 7, 2004, and was diagnosed with a history of chronic Hepatitis B on March 27, 2004.

28. If MetLife had been aware of the Decedent's medical history, MetLife would not have approved the Policy as it did.

29. In light of these findings, MetLife declined coverage under the Policy. *See Exhibit 1.*

30. MetLife has refunded all premiums, plus interest, paid under the Policy to the Plaintiff.

CAUSES OF ACTION

COUNT ONE: RESCISSION FOR MISREPRESENTATION

1. The allegations of paragraphs 1 through 30, set forth above, are incorporated herein by reference as if re-stated in their entirety.

2. The information provided within the Application misrepresents the Decedent's medical history as set forth in paragraphs 4-22 and 27-29 above.

3. These misrepresentations, omissions, concealment of facts and/or incorrect statements were made for the purpose of inducing MetLife to issue life insurance coverage to the Decedent.

4. These misrepresentations, omissions, concealment of facts and/or incorrect statements were material to the issue of whether, and in what amount, the Decedent would receive insurance coverage from MetLife.

5. MetLife reasonably relied upon these misrepresentations, omissions, concealment of facts and/or incorrect statements, delineated herein, and issued coverage to the Decedent based on such reasonable reliance.

6. Had MetLife known the true facts of the Decedent's medical history, MetLife would not have issued the Policy to the Decedent, or would have issued coverage subject to different terms, limitations, and premiums.

7. Based upon these misrepresentations during the application process, the Policy is void *ab initio*.

WHEREFORE, MetLife respectfully requests that this Honorable Court enter a judgment or order: (i) rescinding the Policy; (ii) dismissing each and every cause of action set forth in the Complaint, with prejudice; (iii) awarding costs and disbursements of this action, including reasonable attorneys' fees; and (iv) providing such other and further relief as the Court deems just and proper.

Dated: August 14, 2007
Long Island City, NY

METROPOLITAN LIFE INSURANCE COMPANY

By: _____

Alvin Pasternak
Tomasita Sherer, of Counsel
Attorneys for Defendant
One MetLife Plaza
27-01 Queens Plaza North
Long Island City, NY 11101
(212) 578-3102 (Tel)

CERTIFICATE OF SERVICE

I hereby certify that on this 14th day of August, 2007, copies of the foregoing Revised Answer, Affirmative Defenses, and Counterclaim were filed on ECF and served by first-class U.S. mail, postage prepaid, upon:

Eric Dinnocenzo, Esq.
TRIEF & OLK
Attorneys for Plaintiff
150 East 58th Street, 34th Floor
New York, NY 10155
(212) 486-6060

Dated: August 14, 2007
Long Island City, NY

METROPOLITAN LIFE INSURANCE COMPANY

By: _____

Alvin Pasternak
Tomasita Sherer, of Counsel
Attorneys for Defendant
One MetLife Plaza
27-01 Queens Plaza North
Long Island City, NY 11101
(212) 578-3102 (Tel)

EXHIBIT 1

MetLife
700 Quaker Lane, PO Box 330, Warwick, RI 02887-0330

File Copy
Name _____ Destroy Date _____
Micro Date _____
Refer Date _____

Jean Lin
38 Daisy
Irvine CA 92618

February 5, 2007

Re: Insured Bang C Lin
Policy 204 126 416 ET

Dear Mrs. Lin,

We are supplementing our previous correspondence concerning your claim under this policy.

The policy, which was issued on September 6,2004, provided in part that we would not contest the validity of the policy after it has been in force during the life of the insured for two years from the date of issue, except for nonpayment of premiums. Since your husbands unfortunate death on August 11,2006 occurred within the contestable period of the policy, we conducted our usual inquiries in claims of this nature. Previously we were conducting inquiries on his disability claim as his disability also occurred within the policy's contestable period. Since his death these inquiries were combined and continued to conclusion.

We have learned, in addition to other relevant facts, that your husband was seen by his attending physician on several occasions from September 5,1998 to August 7,2004 for a condition which is serious from an underwriting standpoint. If your husband had disclosed his treatment for this condition, which was material to our acceptance of the risk, his application would not have been approved as issued.

We are obliged to deny liability. Since the policy is voided, we are making payment to you an amount equal to the premiums which were received with interest. I am enclosing our check in the amount of $1,763.00 representing the premium refund amount of $1,620.00 plus interest of $143.00.

If you feel it would be helpful, you may have this matter reviewed by the California Insurance Department, Claims Service Bureau, 11Floor, 300 South Spring Street, Los Angeles, California 90013. Their telephone number is 1-800-927-4357.

We are very sorry that the circumstances compel us to make this unfavorable decision.

Sincerely,

Mary Stewart, Director
MetLife Claims Unit

EXHIBIT 2

Application for Individual and Multi-Life Life Insurance

Metropolitan Life Insurance Company
One Madison Avenue
New York, NY 10010-3690

New England Life Insurance Company
501 Boylston Street
Boston, MA 02116-3700

General American Life Insurance Company
700 Market Street
St. Louis, MO 63101

MetLife Investors USA Insurance Company
222 Delaware Ave, Suite 900
P.O. Box 25130
Wilmington, DE 19899

MetLife Investors Insurance Company
700 Market Street
St. Louis, MO 63101

BELOW ARE INSURANCE FRAUD WARNING STATEMENTS THAT APPLY TO RESIDENTS OF SPECIFIC STATES. PLEASE READ IF THE STATE IN WHICH THE OWNER RESIDES IS LISTED.

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma, Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance and civil damages. It is also unlawful for any insurance company or agent of an insurance company to knowingly provide false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Washington D.C., Maine, Tennessee, Virginia
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

Florida
Any person who knowingly and with the intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

2387715 -4

Part I

Company Use Only (Policy Numbers/Billing/MSA Number)

☑ Metropolitan Life Insurance Company
☐ New England Life Insurance Company
☐ General American Life Insurance Company
☐ MetLife Investors USA Insurance Company
☐ MetLife Investors Insurance Company

The Company indicated above is referred to as "the Company".

1. Proposed Insured #1: Life 1

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number
BANG LIN	M	8/6/69	TAIWAN	085-66-4606

a) Current Residence Address and Phone Number:
7 GREEN Hollow (Street), IRVINE (City), CA (State) 92620 (Zip)
(714) 734-9029 (Home Phone) (858) 756-2722 (Work Phone) Best time and place to call: after 10 am ☑ a.m. ☐ p.m. ☐ Home ☑ Work
E-Mail Address: _____

b) Driver's License Number and State of Issue: A9644172 exp. 8/6/08

c) Employer's Name: Uni Micro

d) Occupation & Duties: President

e) Earned Annual Income: $ 150,000- Net Worth: $ 2,500,000-

f) Are you actively at work? ☑ Yes ☐ No (If No, provide details) _____

2. Proposed Insured #2: Life 2 or Spouse/Covered Insured/Applicant's Waiver of Premium Benefit (For multiple persons under a Covered Insured rider, complete Other Insureds Supplement for additional persons.)

Name: First, Middle, Last	Sex	DOB Mo./Day/Yr.	State/Country of Birth	Social Security Number	Relationship to Proposed Insured #1

a) Current Residence Address and Phone Number (if different than Proposed Insured #1):
_____ (Street) (City) (State) (Zip)
(___) _____ (Home Phone) (___) _____ (Work Phone) Best time and place to call: _____ ☐ a.m. ☐ p.m. ☐ Home ☐ Work
E-Mail Address: _____

b) Driver's License Number and State of Issue: _____

c) Employer's Name: _____

d) Occupation & Duties: _____

e) Earned Annual Income: $ _____ Net Worth: $ _____

f) Are you actively at work? ☐ Yes ☐ No (If No, provide details) _____

2387715 -5

3. ...sting or applied for insurance, including any term riders or annuities: (If additional space is needed, provide details in the Supplemental Information section. If any existing insurance, complete state replacement forms as necessary.) If no existing or applied for insurance or annuity, check here. ☐ **[Type: Life (L), Disability (D), Health (H), Annuity (A)]**

Proposed Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	1035
Insured	MetLife	L	500K	99	500,000 –	☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

4. In connection with this application, has there been, or will there be, with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? (If Yes, complete the Replacement Questionnaire and Disclosure and any applicable replacement forms.) ☐ Yes ☑ No

5. Indicate Plan and Face Amount: ☐ **list below or** ☐ **complete Product Supplement.**

a) Type of Insurance: ☑ Individual Life ☐ Survivorship/Joint Life

☐ Group Conversion (For MetLife only.) (Complete Product Supplement.) ☐ Qualified Plan (Employee Group Number _____)

b) Plan: 15 years Term c) Face Amount: $ 1,000,000 –

Complete for Universal Life/Variable Life Products. (For Variable Life, also complete Variable Life Supplement.)

d) Planned Premium (modal): Year 1: $ _____ Excess/Lump Sum: $ _____

Renewal (If applicable): $ _____ Planned Annual Unscheduled Payment (If applicable): $ _____

e) Definition of Life Insurance Test (If choice is available under policy applied for.):

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

f) Death Benefit Option/Contract Type: _____

g) Guarantee to Age: _____ or ☐ 5 Years (for MetLife Variable only.)

h) **Optional Benefits/Riders/Dividend Option:** ☐ **list below or** ☐ **complete Product Supplement.**

disability waiver	

i) **Special Requests/Other: list below**

$72.-/month

j) Do you request an alternate/additional policy (If available)? ☐ Yes ☐ No
(If Yes, provide full details in Supplemental Information section and include signed and dated illustration for each policy requested.)

6. MODE OF PAYMENT

a) Mode of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☑ Bank Draft
☐ Special Accounts _____ ☐ Other _____

(Additional details/existing/new account numbers, etc.): _____

b) Amount collected with application $ 72.- must equal at least one monthly premium.

7. SOURCE OF PAYMENT (Check all that apply:)

☐ Earned Income ☐ Money Market Fund ☐ Certificate of Deposit
☐ Rollover/Transfer of Assets ☑ Savings ☐ Loan ☐ Other _____
☐ Mutual Fund/Brokerage Account ☐ Use of values in another Life Insurance/Annuity Contract

2387715 -6

8. What is the purpose of this insurance? (Check all that apply:) ☐ Income Protection ☐ Business Planning
☐ Estate Planning ☒ Mortgage Protection ☐ Retirement Supplement ☐ Education Funding
☐ Final Expenses ☐ Charitable Giving ☐ Other _____

Provide the following information for all Primary/Contingent Owners and Beneficiaries:
name; relationship to Proposed Insured(s); date of birth; social security/tax ID number; and address. Include E-Mail address. If Trust, provide Trustee Name and Date of Trust. Indicate additional: Owners; Contingent Owners; Primary Beneficiaries; and Contingent Beneficiaries in Supplemental Information section.

9. Owner/Contingent Owner Information

a) Identity of Owner: Proposed Insured #1 ☒ #2 ☐

Jean Lin 50%
5/19/71 Spouse
128-64-5329

b) Identity of Contingent Owner (if applicable):

10. Beneficiary Information

Note: Multiple beneficiaries will receive equal proceeds unless otherwise requested by Owner.

a) Identity of Primary Beneficiary: ☐ Owner

Jean Lin
5/19/71 Spouse
128-64-5329

b) Identity of Contingent Beneficiary:

Chelsey Lin 50%
11/3/96
daughter
S.S.#: 626-92-1165

Angus Lin 50%
11/9/95
S.S.#: 604-86-5448
Son

☐ Check here if all present and future natural or adopted children of Proposed Insured #1 are to be included as Contingent Beneficiaries.

11. Billing/Mailing Address:*

☒ Proposed Insured #1 Residence Address:*
☐ Proposed Insured #2 Residence Address
☐ Owner's Address (If not Owner listed in question 9a, indicate name and address below.)
☐ Primary Beneficiary's Address (If not Beneficiary listed in question 10a, indicate name and address below.)
☐ Other Premium Payer (Indicate name and address below.)

(If Other, indicate relationship to Proposed Insured(s).) _____
Relationship

_____
(Name: Address: Street City/ State/ Zip)

*If any other special mailing arrangements are needed, indicate in Supplemental Information section.

2387715 -7

12. Any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) ☐ Yes ☒ No

a) Amount of insurance on spouse: Existing: $ _____ Applied For: $ _____

b) If dependent minor, are there any other siblings insured for less than this child? (If Yes, provide details in Supplemental Information section.) ☐ Yes ☒ No

c) Amount of existing and applied for insurance on parents of dependent minor:

	Amount			Amount	
Father's Name	Existing	Applied For	Mother's Name	Existing	Applied For

Part II

13. Within the past three years has any person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? (If Yes, complete Aviation Supplement.) ☐ Yes ☒ No

14. Within the past three years has any person to be insured participated in or intend to participate in any: underwater sports (SCUBA diving, hardhat, skin diving, snorkeling); sky sports (skydiving, hang gliding, parachuting, ballooning); racing sports (motorcycle, auto, motor boat); rock or mountain climbing; bungee jumping or other similar activities? (If Yes, complete Avocation Supplement.) ☐ Yes ☒ No

15. Are all persons to be insured U.S. citizens? (If No, provide details below including: country of citizenship; Visa/ID Card type; number; and expiration date.) ☒ Yes ☐ No

16. Has any person to be insured traveled or resided outside the U.S. or Canada in the past two years OR does any person to be insured intend to travel or reside outside the U.S. or Canada in the next 12 months? (If Yes, provide details below including: country; city; duration; and purpose.) ☐ Yes ☒ No

17. Has any person to be insured ever used tobacco products: (e.g. cigarettes; cigars; pipes; smokeless tobacco; chew) or nicotine substitutes: (e.g. patch or gum)? (If Yes, provide type, amount, date last used, and frequency below.) ☐ Yes ☒ No

18. Has any person to be insured: ever had a driver's license suspended or revoked; ever been convicted of DUI or DWI; or had any moving violations in the last five years? (If Yes, provide details below.) ☐ Yes ☒ No

Give details for question 15 through 18. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number(s)	Date	Details

19. Attending Physician(s) of the Proposed Insured(s): (Provide: name; address; phone number; date; and reason for last consultation. Attach additional sheet(s), if necessary.)

Proposed Insured #1

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment
Dr. James Hwang 740 W. Central Ave. #119 Brea, CA 92821 714-990-0325	8/04 Regular check up Normal

Proposed Insured #2

Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment

20. Proposed Insured #1 Height: 5'6" Weight: 165	Proposed Insured #2 Height: _____ Weight: _____

21. Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had: (Provide details for each Yes answer below.)

- **a)** High blood pressure; chest pain; heart attack; or any other disease or disorder of the heart or circulatory system? ☐ Yes ☒ No
- **b)** Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the respiratory system? ☐ Yes ☒ No
- **c)** Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Parkinson's; or any other disease or disorder of the brain or nervous system? ☐ Yes ☒ No
- **d)** Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines? ☐ Yes ☒ No
- **e)** Any disease or disorder of: the kidney; bladder; or prostate; or protein or blood in the urine? ☐ Yes ☒ No
- **f)** Diabetes; thyroid disorder; or any other endocrine disorders? ☐ Yes ☒ No
- **g)** Arthritis; gout; or disorder of the muscles, bones, or joints? ☐ Yes ☒ No
- **h)** Cancer; tumor; polyp; cyst; anemia; leukemia; or any other disorder of the blood or lymph glands? ☐ Yes ☒ No
- **i)** Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms? ☐ Yes ☒ No

22. Has any person proposed for insurance: (Provide details for each Yes answer below.)

- **a)** In the past six months, taken any medication or been under observation or treatment? ☐ Yes ☒ No
- **b)** Scheduled any: doctor's visits; medical care; or surgery for the next six months? ☐ Yes ☒ No
- **c)** During the past five years had any: checkup; health condition; or hospitalization not revealed above? ☐ Yes ☒ No
- **d)** Ever been diagnosed with, treated by a medical professional for, or tested positive during a medical examination for life insurance for; any of the following: Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); AIDS (Human Immunodeficiency Virus (HIV)) virus; or antibodies to the AIDS (HIV) virus? ☐ Yes ☒ No
- **e)** Ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner? ☐ Yes ☒ No
- **f)** Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem? ☐ Yes ☒ No

23. Answer Question 23 only when requesting the Long-Term Care Guaranteed Purchase Option.
(Provide details for each Yes answer below.)

- **a)** Do you currently use any mechanical equipment i.e.: a walker; wheelchair; leg braces; or crutches? ☐ Yes ☐ No
- **b)** Do you need any assistance; or supervision with the following activities bathing; dressing; walking; moving in/out of a chair or bed; toileting; continence; or taking medication? ☐ Yes ☐ No

Give details of each Yes answer from Questions 21, 22, and 23. Attach additional sheet(s), if necessary.

Proposed Insured	Question Number	Name/Address of Physician	Date/Duration Illness	Diagnosis/Severity/Treatment

2387715

9

24. ...s a parent or sibling of any person to be insured ever had heart disease, coronary artery disease, high blood pressure, cancer, diabetes or mental illness? (If Yes, complete rest of question 24.) ☐ Yes ☒ No

Relationship to Proposed Insured #1:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Relationship to Proposed Insured #2:	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death (Attach additional sheet(s), if necessary.)

Supplemental Information Section or Special Requests from Agent/Producer. Attach additional sheet(s) if necessary.

Home Office Endorsements: (Not applicable to: FL, KY, MD, MA, MN, MO, OR, PA, PR, WV, WI.)

ENB-7-04-CA

2387715 -10

AGREEMENT/DISCLOSURE

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- My acceptance of any insurance policy means I agree to any changes shown in the Home Office Endorsements section, where state law permits Home Office endorsements.
- This application and any: amendment(s); paramedical/medical exam; and supplement(s) that become part of the application, will be attached to and become part of the new policy.
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No information will be deemed to have been given to the Company unless it is stated in this application and its supplement(s), paramedical/medical exam, and amendment(s).
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 4 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.
- If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.

Substitute Form W-9 – Request for Taxpayer Identification Number

Under penalties of perjury, I, Jean Lin (Owner's Name) (128-64-5329 (Owner's Taxpayer ID #)) **certify:**

1) That the number shown above is my correct taxpayer identification number; and
2) That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and
3) I am a U.S. citizen or a U.S. resident for tax purposes.*

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form **W-8BEN**.

Signatures:

	Signed at City, State	Mo./Day/Yr.	Signature
Owner* (age 15 or over) (If other than a Proposed Insured)	Irvine, CA	8/5/04	X
Proposed Insured #1 (age 15 or over)	Irvine, CA	8/5/04	X
Proposed Insured #2 (age 15 or over)			X
Parent or Guardian or person liable for child's support			X

(Signature required if Owner or Proposed Insured(s) is/are under the age of 18 and the Parent, Guardian or person liable for the child's support has not signed above.)

Witness to Signatures (Licensed Agent/Producer)	Irvine, CA	8/5/04	X

***If the Owner is a Firm or Corporation, include Officer's Title with signature. (Officer signing must be other than a Proposed Insured.)**

PART II: Paramedical/Medical Exam

Case/Policy No.: 20412646

- [x] Metropolitan Life Insurance Company
- [ ] MetLife Investors Insurance Company of California
- [ ] New England Life Insurance Company
- [ ] Texas Life Insurance Company
- [ ] Metropolitan Tower Life Insurance Company
- [ ] Metropolitan Insurance and Annuity Company
- [ ] MetLife Investors USA Insurance Company
- [ ] General American Life Insurance Company

The Company indicated above is referred to as "the Company".
For Texas Life: If medical examination *is not* required: questions are to be completed by Agent.

The spaces below are for answers of person to be examined only. Nothing but the answers of such person should be recorded.

1. Name of Proposed Insured: (Last, First, Middle): LIN. BANG C — Date of Birth: (Mo./Day/Year): 08-06-1969

2. Tobacco Use – Indicate date last smoked/used:

Cigarette	Smokeless Tobacco	Cigar/Pipe	Patch/Gum
__/__/__ [x] Never	__/__/__ [x] Never	__/__/__ [x] Never	__/__/__ [x] Never

Amount/Frequency:

Tobacco Never Used: [x] Yes [ ] No

3. Who is the doctor, practitioner, or health care facility who can give us the most complete and up to date information concerning your present health? If "None", check ☐.

Name, full address, and phone number: DR. JAMES HUANG (714) 990-03[illegible]
340 WEST Central AVE #119. BREA, CA 92821

When was this doctor last consulted? 08/2004 — Why? SKIN Itching

What treatment was given or medication prescribed? If "None", check [x]

Reasons, findings, earlier consultations past 5 years? — WNL

4. a) Height 5 ft. 8 in. b) Weight 170 lbs. c) Change in weight in past 12 months (give reason) Pounds lost — Pounds gained — Reason

5. Have you EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that you had:

		Details: List question number. Give: details; dates; duration; diagnosis; treatment; and doctors' names and addresses.
a) High blood pressure; chest pain, heart attack; or any other disease or disorder of the heart or circulatory system?	☐ Yes [x] No	
b) Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the lungs or respiratory system?	☐ Yes [x] No	
c) Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Lou Gehrig's disease (ALS); memory loss; Parkinson's disease; progressive neurological disorder; headaches; dizziness; or any other disease or disorder of the brain or nervous system?	☐ Yes [x] No	
d) Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of: the liver, gallbladder; stomach; or intestines?	☐ Yes [x] No	
e) Any disease or disorder of: the kidney; bladder; prostate; reproductive organs; or breasts; sexually transmitted disease; sugar; albumin; blood or pus in the urine?	☐ Yes [x] No	
f) Diabetes; thyroid disorder; or any other endocrine disorder?	☐ Yes [x] No	
g) Arthritis; gout; or disorder of the muscles, bones, or joints?	☐ Yes [x] No	
h) Cancer; tumor; polyp; or cyst? Any disease or disorder of the skin?	☐ Yes [x] No	

Details (Continued):

	i) Anemia; leukemia; or any other disorder of the blood or lymph glands?	☐ Yes ☒ No	
	j) Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐ Yes ☒ No	
	k) Any disease or disorder of the eyes, ears, nose, or throat?	☐ Yes ☒ No	
6.	Are you now, or within the last six months, under observation or taking medication or treatment? (Including over the counter medications, vitamins, herbal supplements, etc.)	☐ Yes ☒ No	
7.	Do you have any doctor's visits, medical care, or surgery scheduled?	☐ Yes ☒ No	
8.	Other than the above, during the past five years have you had any:		
	a) Checkup; electrocardiogram; chest x-ray; or medical test?	☐ Yes ☒ No	
	b) Illness; injury; or health condition not revealed above; or have been recommended to have any: treatment; hospitalization; surgery; medical test; or medication?	☐ Yes ☒ No	
9.	Have you:		
	a) ever been diagnosed or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	☐ Yes ☒ No	
	b) ever tested positive during a medical examination for life insurance for the AIDS (HIV) virus or for antibodies to the AIDS (HIV) virus?	☐ Yes ☒ No	
10.	a) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐ Yes ☒ No	
	b) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐ Yes ☒ No	

11. Do you exercise? ☒ Yes ☐ No Type: SWIMMING / GOLF How often? 2 times/wk 1-3 hrs

12. Are you now pregnant? ☐ Yes ☐ No If "Yes", estimated date of delivery? _____

13. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, indicate below.) ☐ Yes ☒ No

Relationship to Proposed Insured:	Age(s) If Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death Attach additional sheet(s) if necessary.

14. a) Do you currently use any mechanical equipment such as a walker, wheelchair, long leg braces or crutches? ☐ Yes ☒ No.

b) Do you need any assistance or supervision with the following activities: bathing, dressing, walking, moving in/out of a chair or bed, toileting, continence or taking medication? ☐ Yes ☒ No

I have read the answers to questions 2-14 before signing. They have been correctly written, as given by me, and are true and complete to the best of my knowledge and belief. There are no exceptions to any such answers other than as written.

Witness to Signature	City and State	Mo./Day/Year	Signature of Proposed Insured (Parent or Guardian if under 18)
[signature]	IRVINE, CA	08/18/04	[signature]

Chan Peggy

Report of Paramedical/Medical Examiner

- **Complete Sections I and III for Paramedical Exam**
- **Complete Sections I, II and III for Physician's Exam**

Section I

1. (a) Date of birth 08-26-69 (b) Sex M ☒ F ☐ (c) If female, was proposed insured menstruating on date of this examination? Yes ☐ No ☐

2. Height (in shoes)	Weight (clothed)	Chest (full inspiration)	Chest (forced expiration)	Abdomen (at umbilicus)
5 ft 8 in.	170 lbs.	Males 38 in.	Males 36 in.	Males 33 in.

Did you measure? Yes ☒ No ☐ Did you weigh? Yes ☒ No ☐

3. Blood Pressure (Record ALL readings – at least two):

Sitting Systolic/Diastolic – 5th phase	If systolic over 140 or diastolic over 90, repeat later in exam	
141 / 76	120 / 76	/

4. Pulse At Rest: Rate (per min.) 76 Irregularities (per min.) 0
5. Is appearance unhealthy or older than stated age? Yes ☐ No ☒
6. Urinalysis: Protein: Positive ☐ Negative ☒ Sugar: Positive ☐ Negative ☒
   Is blood also being sent to lab? Yes ☒ No ☐ ECG done?: Yes ☐ No ☒

0058848765

for analysis re

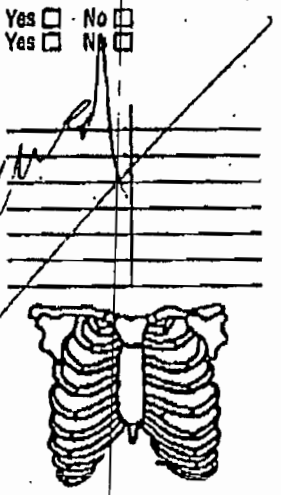
Details for answers to questions 7–11.

Section II

7. Heart: Is there any:
   a) Enlargement? Yes ☐ No ☐ c) Dyspnea? Yes ☐ No ☐
   b) Murmur(s)? Yes ☐ No ☐ d) Edema? Yes ☐ No ☐
   (If Yes, complete below)

	Murmur 1	Murmur 2
Location (Apical, Aortic, Pulmonic, Parasternal)		
Timing (Systolic, Presystolic, Diastolic)		
Quality (Coarse, Blowing, Rumbling, Musical)		
Loudness (Grade 1–6)		
Constant (Yes or No)		
Transmitted (Yes or No)		
After Exercise (Increased, Absent, Unchanged, Decreased)		

Indicate:
Apex by: X
Murmur area by: ☐
Point of greatest intensity by: 0
Transmission by: →



8. Is there on examination any abnormality of the following?	☐ Yes	☐ No
a) Eyes, ears, nose, mouth pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐ Yes	☐ No
b) Skin (include scars); lymph nodes; varicose veins or peripheral arteries?	☐ Yes	☐ No
c) Nervous system (include reflexes, gait, and paralysis)?	☐ Yes	☐ No
d) Respiratory system?	☐ Yes	☐ No
e) Abdomen (describe scars, liver enlargement)?	☐ Yes	☐ No
f) Genitourinary system?	☐ Yes	☐ No
g) Endocrine system (include thyroid)?	☐ Yes	☐ No
h) Musculoskeletal system (include spine, joints, amputations, and deformities)?	☐ Yes	☐ No
9. Are there any hernias?	☐ Yes	☐ No
10. Are you aware of additional medical history?	☐ Yes	☐ No
11. Are you the personal physician of the applicant?	☐ Yes	☐ No

12. Please provide your overall clinical impression of proposed insured:

08/18/04

Section III Name of person examined _____ Date/Time of exam 10:00 AM

Place of exam: ☐ Examiner's office ☐ Proposed Insured's Residence ☒ Proposed Insured's Business

City/State IRVINE, CA

Agent/Broker _____ Branch/District # or Agency Name APPS #09

Signature of Paramedical/Medical Examiner _____ Address 9465 Wilshire Blvd. #336

Printed Name _____ Los Angeles, CA 90010

Tel: 818-889-2777

Tax: 112298722

EXHIBIT 3

MetLife®

For Company use only:
Branch/District and Agency Numbers 95L / 818-1

Payment Direction (circle one): Payee (Branch/District) Broker

Individual Life Death Claim Form

In order to process your claim as quickly as possible we need some information about you and the insured. Please submit the insurance policies, and an official certified copy of the death certificate with the claim form. Each claimant must submit his or her own claim form. Only one certified copy of the death certificate must be submitted.

A. Insured Information

Name BANG CHAO LIN Date of Death ~~8/6/1969~~ 8/11/2006

Please list all life insurance policy numbers on which you are filing claim

993001679 PR-R 204126416 ET

All policies listed below (except those where claim is being made under a Waiver of Premium rider) should be submitted with your claim.

If policies are not attached, please state why:

Address 38 (Number) DAISY (Street Name), IRVINE. (Apt/Box # (if any)) CA (City) 92618 (State Zip)

Marital Status: Single ____ Married ✓ Widow/Widower ____ Separated ____ Divorced ____

Date of Birth 8/6/1969 Place of Birth TAIWAN

Is Claim being made for Accidental Death Benefits? Yes ____ No ✓ (If yes, please refer to the Additional Information on page 6.)

If you would like us to check for additional life insurance coverage with MetLife or with one of our affiliates listed below, please be sure to complete Section G of the claim form on page 4.

B. Claimant Information

Name JEAN LIN Date of Birth 5/19/1971 Sex: Male ____ Female ✓

Social Security or Trust/Estate Identification Number or Social Security Number of any minor child: 128 / 64 / 5329

Phone Number (in case we need to contact you). Day (949) 551-6301 Evening (____)

Address 38 (Number) DAISY (Street Name), IRVINE. (Apt/Box # (if any)) CA (City State Zip)

Your relationship to the insured. Husband /Wife ✓ Child ____ Other ____ (Explain)

E-mail Address (if available) ____

C. Claimant Signature & Tax Certification

Your Social Security or Trust/Estate Identification Number or Social Security Number of the minor child: ____ / ____ / ____

If you are claiming on behalf of a minor child, please provide the child's name, address, and telephone number

Under the penalties of perjury I certify:

1) That the number shown above is my correct taxpayer identification number; and 2) That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and (3) I am a U.S. citizen or U.S. resident for tax purposes. **(Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income. The Internal Revenue Service does not require your consent to any document other than the certifications to avoid backup withholding.)*

***If you are not a U.S. Citizen or a U.S. resident for tax purposes, please complete form W-8BEN.**

Sign Here (2) _____ (Your Signature) 9/19/06 (Date)

_____ (Witness' Signature) 9/19/06 (Date)

JUDY HUANG (Print Witness' Name) 17800 CASTLETON ST, #218, CITY OF INDUSTRY, CA 91748 (Witness' Address)

First MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
MetLife Investors Insurance Company of CA